

IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2010 MTWCC 11

WCC No. 2009-2210

JOE WRIGHT

Petitioner

vs.

ACE AMERICAN INSURANCE COMPANY¹

Respondent/Insurer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: Petitioner suffered an industrial injury to his left shoulder. After surgery, his shoulder pain worsened and he also experienced cervical symptoms. Although Petitioner subsequently saw several doctors, none offered viable treatment options except pain management. Petitioner sought medical treatment on his own with a former Billings doctor, now practicing in Wyoming, who recommended a second shoulder surgery. Respondent has denied Petitioner's request for that surgery. Petitioner further alleges that he is unable to work and should receive TTD benefits. Respondent alleges that Petitioner's treating physician signed job analyses and has released him to return to work, thereby rendering him ineligible for TTD benefits.

Held: Petitioner is entitled to additional medical benefits. Although Petitioner's treating physician, a pain management specialist, does not recommend further surgical treatment, the Court finds the opinion of an orthopedic surgeon, who believes Petitioner is likely to improve with additional surgery, more persuasive. Since additional medical treatment is reasonably expected to improve Petitioner's condition, he is not at MMI. Since he also has not been released to return to his time-of-injury employment, he is entitled to TTD benefits. As the prevailing party, Petitioner is entitled to his costs. Petitioner has not demonstrated

¹ The parties stipulated that this is the correct party name for Respondent and the caption has been amended accordingly; see Docket Item Nos. 38 and 39.

that Respondent was unreasonable in adjusting his claim and therefore Petitioner is not entitled to attorney fees or a penalty.

¶ 1 The trial in this matter was held on January 20, 2010, in Billings, Montana. Petitioner Joe Wright (Wright) was present and represented by Patrick R. Sheehy. Respondent ACE American Insurance Company² (ACE) was represented by Charles G. Adams.

¶ 2 Exhibits: Exhibits 1 through 8 were admitted without objection.

¶ 3 Witnesses and Depositions: Wright, Bette M. Wright, and Travis Stortz, CRC, were sworn and testified at trial. The parties agreed that the two depositions of Wright, taken March 19, 2007, and March 13, 2009, and the depositions of Michael Schabacker, M.D., Gregg Singer, M.D., and Jeffrey Hansen, M.D., can be considered part of the record.

¶ 4 Issues Presented: The Pretrial Order² states the following contested issues:

¶ 4a Whether the insurer is liable for payment of additional medical benefits and temporary total disability benefits to the Petitioner.

¶ 4b Whether Petitioner is entitled to an award of reasonable attorneys' fees and costs from the Respondent.

¶ 4c Whether Petitioner is entitled to the 20% penalty from the Respondent.

¶ 4d For such additional relief as the Court may deem appropriate.

FINDINGS OF FACT

¶ 5 At trial, the parties stipulated that Wright received temporary total disability (TTD) benefits from July 7, 2006, to January 8, 2007, and from September 25, 2007, to January 11, 2009.

¶ 6 Wright testified at trial. I found him to be a credible witness. Wright began working at Interstate Brands, Inc. in April 2004. His usual job was to work as a bread wrapper. On October 24, 2004, Wright was removing pallets from a jammed conveyor belt when the

² Pretrial Order at 2, Docket Item No. 37.

conveyor belt started up and jerked his left arm. Wright continued to work for a few hours; however, he was in pain and left early. His employer sent him to the hospital emergency room. The following day, he was seen by PA-C Ronald K. Handlos (Handlos) at the Billings Clinic. Wright complained of arm and shoulder pain.³

¶ 7 Handlos released Wright to work, but restricted him from using his left arm. Wright testified that his employer did not accommodate the restriction, but assigned him cleaning tasks that were impossible to perform with one arm. Wright stated that his left shoulder pain intensified during the time he attempted to perform the duties assigned to him.⁴

¶ 8 Wright first saw Matthew Kopplin, M.D., on referral from Handlos on December 14, 2004. Dr. Kopplin recommended rest to allow his epicondylar area to heal. Dr. Kopplin opined that Wright would likely need an arthroscopic evaluation of his left shoulder with subacromial decompression, probable distal clavicle excision, and probable open ganglion excision/evacuation.⁵

¶ 9 Dr. Kopplin saw Wright for a follow-up appointment on January 6, 2005. Dr. Kopplin reviewed an MRI and found supraspinatus tendonitis, Type II or Type III acromion, and a ganglion in the posterior aspect along the site of the scapula between the infraspinatus and supraspinatus. He recommended surgical intervention, followed by one to three months off work for recovery.⁶

¶ 10 On January 12, 2005, Dr. Kopplin performed surgery on Wright's left shoulder. The surgery included a left shoulder arthroscopy and arthroscopic subacromial decompression, arthroscopic distal clavicle excision, open excision of posterior ganglion, and arthroscopic debridement of torn labrum. In his surgical notes, Dr. Kopplin stated that Wright's rotator cuff was intact, but the labrum showed fraying and degenerative tear on the anterior superior area. Dr. Kopplin resected it with an arthroscopic shaver. He further examined the posterior labrum for tears and found none. He also inspected the rotator cuff through the subacromial side and found it to be intact in that area.⁷

³ Trial Test.

⁴ Trial Test.

⁵ Ex. 3 at 110-11.

⁶ Ex. 3 at 108-9.

⁷ Ex. 3 at 103-5.

¶ 11 At first, Wright's recovery from surgery proceeded as expected, but on February 4, 2005, Dr. Kopplin noted some concern with his recovery and range of motion.⁸ On February 15, 2005, Dr. Kopplin noted that Wright was experiencing some nerve irritation or possibly a mild reflex sympathetic dystrophy-type problem. Dr. Kopplin opined that Wright could not do any work involving his left arm, but could do right-handed tasks.⁹

¶ 12 Wright continued to report ongoing pain in his left arm and shoulder. On March 9, 2005, Dr. Kopplin expressed concern that Wright was experiencing reflex sympathetic dystrophy (RSD) and could have an associated cervical spine problem. He recommended a second opinion to evaluate Wright's neck and discuss RSD.¹⁰ Dr. Kopplin took Wright off work.¹¹

¶ 13 Wright testified that he regrets having the January 2005 surgery because his pain has worsened significantly since then.¹² Wright stated that his left shoulder was more painful after surgery than it had been on the day of his industrial injury.¹³

¶ 14 On March 15, 2005, Scott K. Ross, M.D., saw Wright for an occupational medical consultation. Dr. Ross reviewed Wright's medical history. Dr. Ross recorded Wright's pain complaints, medications, and his report of daily activities. Upon physical examination, Dr. Ross found no objective medical findings to correlate with Wright's complaints of left shoulder pain. Dr. Ross opined that Wright's pain responses were exaggerated and that his examination had inconsistencies. He further opined that Wright was not at maximum medical improvement (MMI) and should remain off work. Dr. Ross recommended a neurology consultation with electrodiagnostic testing, a neuropsychological evaluation, left shoulder MR arthrogram, and possibly an orthopedic second opinion. He recommended the continuation of physical therapy and a home exercise program.¹⁴

⁸ Ex. 3 at 100.

⁹ Ex. 3 at 98.

¹⁰ Ex. 3 at 95.

¹¹ Ex. 3 at 94.

¹² Trial Test.

¹³ Wright Dep. (2007) 19:6-15.

¹⁴ Ex. 3 at 134-45.

¶ 15 On March 23, 2005, Blackshear M. Bryan, M.D., examined Wright. Dr. Bryan noted that Wright's recovery from surgery had been prolonged, and that Wright was reporting his shoulder was more painful now than it was prior to the surgery. Dr. Bryan could not pinpoint the cause of Wright's pain and recommended a neurologic consultation. Dr. Bryan recommended that Wright stay off work until his condition was more clearly diagnosed.¹⁵

¶ 16 On April 5, 2005, Wright had an MRI of his left shoulder which found fluid within his acromioclavicular joint as well as within the subacromial/subdeltoid bursa, irregularity within the tendon of the supraspinatus muscle compatible with tendinopathy, some inflammatory signal within the subscapularis tendon "which may represent tendinopathy or partial tear," and fluid surrounding the longhead of the biceps. The MRI further revealed narrowing in the glenohumeral joint. The radiologist's impression was:

Fluid within the subacromial/subdeltoid bursa, which may be related to surgery, although it would [be] difficult to exclude a subtle rotator-cuff tear. Tendinopathy versus partial tear noted within the supraspinatus and within the subscapularis, and there are post-surgical changes in the clavicle, as well as within the infraspinatus.¹⁶

¶ 17 On April 6, 2005, Dr. Kopplin reviewed the new MRI and saw evidence of tendinosis in the subscapularis and in the supraspinatus tendons, but no evidence of a full or large partial thickness tear. Dr. Kopplin's examination of Wright revealed diffuse allodynia over his shoulder with tenderness at all his incisions and global hypersensitivity. Dr. Kopplin found no gross rotator cuff deficit or strength deficit within his range of motion. Dr. Kopplin opined that Wright's pain complaints were nerve mediated; he could not explain the pain complaints on an anatomic basis.¹⁷

¶ 18 On April 26, 2005, John England, M.D., determined that Wright was not at MMI and took him off work indefinitely.¹⁸ On April 28, 2005, Dr. England evaluated Wright to determine whether his condition was related to a neurogenic process. Dr. England reviewed Wright's history and reviewed the recent MRI of Wright's left shoulder. On the MRI, Dr. England saw some post-operative changes in Wright's acromioclavicular joint with

¹⁵ Ex. 3 at 79-81.

¹⁶ Ex. 3 at 268-69.

¹⁷ Ex. 3 at 89.

¹⁸ Ex. 3 at 78.

the probable presence of some fluid within the joint. Dr. England saw irregularity consistent with tendinitis or tendinopathy on the supraspinatus tendon, and post-surgical changes in the infraspinatus muscle with increased signal most likely indicative of inflammation within the subscapularis tendon. Dr. England also saw some fluid around the long head of the biceps tendon. After a physical examination and electrodiagnostic testing, Dr. England's impression was that Wright suffered from persistent postsurgical left shoulder pain and restriction of movement. Dr. England believed that Wright's tenderness and pain suggested a persistent residual inflammation such as tendinitis. Dr. England also found persistent pain around the acromion. Dr. England found no clinical or electrophysiologic evidence of nerve injury, and no evidence of active cervical radiculopathy, brachial plexopathy, or focal neuropathy of the shoulder girdle. Dr. England found exaggerated pain in and around the shoulder consistent with a dynamic mechanical allodynia, but no evidence of complex regional pain syndrome Type I. Dr. England further saw evidence of persistent left lateral epicondylitis. He recommended conservative treatment in the hope that Wright's condition would improve over time.¹⁹

¶ 19 On May 5, 2005, Joseph K. McElhinny, Psy.D., saw Wright and prepared a psychological consultation report. Dr. McElhinny opined that Wright was experiencing a significant adjustment reaction to his left shoulder injury with some depressive symptoms, but no major depressive disorder. Dr. McElhinny thought Wright's pain medications might be adversely affecting his mood. Dr. McElhinny recommended continued physical therapy and possibly a trial of antidepressant medication.²⁰

¶ 20 On May 10, 2005, Dr. Ross saw Wright after Wright had undergone additional diagnostic testing. Dr. Ross considered the new medical information and examined Wright. He opined that Wright was not at MMI, but released him to return to work with restrictions on his use of his left arm. Dr. Ross recommended ongoing treatment with Dr. Kopplin and continued physical therapy.²¹

¹⁹ Ex. 3 at 72-75.

²⁰ Ex. 3 at 66-71.

²¹ Ex. 3 at 123-28.

¶ 21 On May 10, 2005, Dr. Kopplin released Wright to return to work with restrictions on the use of his left arm.²² On May 17, 2005, Dr. Kopplin recommended continued pain management.²³

¶ 22 On June 8, 2005, Dr. Ross reviewed job analyses and approved a modified version of Wright's time-of-injury position as a bread wrapper which took into account lifting restrictions and limited use of Wright's left arm.²⁴

¶ 23 On June 23, 2005, John A. Vallin, M.D., performed an independent medical examination (IME) of Wright. Upon physical examination, Dr. Vallin found normal cervical range of motion, but noted anterior neck pain to the extremes of right and left rotation as well as to extension. Other findings included some tenderness in the shoulder, some restrictions in range of motion, intact rotator cuff strength, and normal right arm strength reflexes and sensation. Dr. Vallin saw no trophic changes of Wright's shoulder or arm. He diagnosed Wright with persistent left shoulder pain. Dr. Vallin opined that Wright was capable of light-duty employment with restrictions on lifting with his left arm. Dr. Vallin recommended a second opinion from an orthopedic surgeon.²⁵

¶ 24 On July 18, 2005, Dr. Kopplin noted that Wright was six months out from his surgery, and that Wright reported continuing pain although he was working hard at physical therapy but has continued to have pain. Overall, Dr. Kopplin found Wright's condition improved.²⁶

¶ 25 On September 13, 2005, Robert B. Blake, M.D., saw Wright for a second opinion. Wright reported significant pain and swelling, with his left shoulder very sensitive to touch. Dr. Blake found that Wright's skin appeared normal, but he had some swelling over the medial border of his left scapula with moderate tenderness to palpation. Among other findings, Dr. Blake noted tenderness along the trapezius, diminished range of motion of the cervical spine with a positive Spurling maneuver to the left, and good strength of his rotator cuff. Dr. Blake noted that Wright "[c]learly . . . has signs and symptoms of a cervical radiculopathy" and recommended a cervical MRI. Dr. Blake further noted that

²² Ex. 3 at 88.

²³ Ex. 3 at 86-87.

²⁴ Ex. 3 at 121-22.

²⁵ Ex. 3 at 50-60.

²⁶ Ex. 3 at 83.

none of Wright's previous MRI scans had shown the medial border of his scapula and he recommended an MRI of the left scapula. Dr. Blake opined that Wright was not at MMI, but was capable of a sedentary job with limited physical demand.²⁷

¶ 26 On September 23, 2005, Dr. Kopplin noted that Wright reported some worsening in his condition since Dr. Kopplin had last seen him in July. Dr. Kopplin noted with approval that Wright was pursuing a second opinion and additional diagnoses and treatment with a Bozeman physician.²⁸ Wright testified that in approximately September 2005, he called Dr. Kopplin's office to make an appointment and was informed by a nurse that Dr. Kopplin was unable to provide additional treatment.²⁹

¶ 27 A cervical spine MRI taken November 25, 2005, revealed diffuse posterior spondylotic ridging, greater on the left, with mild to moderate compromise left-sided neural foramen at C3-4; mild degenerative narrowing of the interspace and mild to moderate spondylotic narrowing of the neural foramina, greater on the right, at C5-6; degenerative narrowing of the interspace with mild to moderate spondylotic compromise left-sided neural foramen with mild narrowing on the right at C6-7.³⁰

¶ 28 An MRI of Wright's left arm, including the scapular region, on November 25, 2005, revealed a small defect in the superolateral humerus and partial tear of the distal supraspinatus tendon. The report notes, "This exam is not protocolled for the rotator cuff. If concern for rotator cuff pathology persists, a dedicated rotator cuff/shoulder protocol may be of benefit."³¹

¶ 29 On December 8, 2005, Scott Riggins, M.D., performed a neurological examination of Wright. Dr. Riggins reviewed MRI scans of Wright's neck and left shoulder. He noted that the cervical MRI revealed mild to moderate neural foraminal narrowing, but no significant nerve impingement or abnormalities in the spinal cord. Dr. Riggins found no

²⁷ Ex. 3 at 39-40.

²⁸ Ex. 3 at 82.

²⁹ Wright Dep. (2007) 26:19 - 27:8.

³⁰ Ex. 3 at 266-67.

³¹ Ex. 3 at 264-65.

significant abnormalities on the shoulder MRI scan. He opined that Wright's neck and shoulder complaints were primarily musculoskeletal.³²

¶ 30 Gregg Singer, M.D., performed two IMEs on Wright, with the first occurring February 3, 2006.³³ Dr. Singer is board-certified in physical medicine and rehabilitation and is a certified independent medical examiner.³⁴ At the first IME, Wright reported left shoulder discomfort which had worsened since his surgery. He also reported weakness and pain in his left shoulder with some numbness in his left elbow and hand.³⁵ Dr. Singer reviewed and summarized Wright's medical records, past surgical history, and current medications.³⁶ On physical examination, Dr. Singer found inconsistent tenderness over the surgical scar, no skin atrophy or changes in texture or quality of skin, and no change in hair distribution. Spurling's maneuver to the right caused left-sided neck pain. Dr. Singer found Wright's cervical range of motion to be limited and "accompanied by significant grimacing." Wright complained of pain with left shoulder motion. Dr. Singer found positive bilateral impingement testing, tenderness at the left AC joint, and tenderness at the left bicipital tendon. Wright reported pain and tenderness with some additional tests.³⁷ Dr. Singer assessed Wright's condition as:

Persistent left shoulder pain post industrial accident of 10/24/04. He is status post left shoulder arthroscopy and subacromial decompression, distal clavicle excision, and excision of posterior ganglion, and debridement of torn labrum on 01/12/05. His pain complaints have persisted far beyond what would be reasonably expected based on the mechanism of injury. His examination is limited by pain behaviors. There are no signs of radiculopathy on examination today. Mr. Wright is a bit irritable and has been diagnosed with an adjustment reaction to his injury by Dr. McElhinny. In my opinion, this is a major component to his persistent complaints of pain.³⁸

³² Ex. 3 at 46-48.

³³ Ex. 3 at 20-31.

³⁴ Singer Dep. 3:13 - 4:3.

³⁵ Ex. 3 at 20-21.

³⁶ Ex. 3 at 21-28.

³⁷ Ex. 3 at 29-30.

³⁸ Ex. 3 at 30.

¶ 31 Dr. Singer opined that Wright was not yet at MMI and that he should continue certain prescription medications for pain relief and possibly be given an antidepressant on a trial basis. Dr. Singer reviewed job analyses and disapproved Wright's time-of-injury job, but approved the positions of courtesy van driver/porter, drafter data collector, network computing technician, receptionist/operator, security officer, and dump truck driver.³⁹

¶ 32 Wright began treating with Cameron Gardner, M.D., for his left shoulder pain on April 7, 2006. Dr. Gardner opined that Wright's left shoulder pain was chronic and unlikely to improve with additional surgery.⁴⁰ Dr. Gardner saw Wright for follow-up care on May 19, 2006, and recommended conservative care with avoidance of narcotics.⁴¹

¶ 33 Wright was terminated from his employment in June or July of 2006, after he had been off work for approximately 18 months.⁴²

¶ 34 Dr. Singer performed a second IME of Wright on July 7, 2006. Dr. Singer reviewed his previous IME and also reviewed and summarized Wright's subsequent medical records. Wright reported that his shoulder and neck pain had worsened since Dr. Singer last saw him.⁴³ After taking a history and conducting a physical examination, Dr. Singer assessed Wright as having chronic pain complaints post left shoulder arthroscopy, subacromial decompression, distal clavicle excision, open excision of posterior ganglion, and debridement of torn labrum, with myofascial pain and a history of depression. Dr. Singer opined that Wright had reached MMI and assigned him a 6% whole person impairment rating. Dr. Singer recommended some medications for pain and depression. Dr. Singer restricted Wright permanently to light-duty work with no overhead activity with his left shoulder.⁴⁴

¶ 35 During a deposition taken in this case, Dr. Singer testified that typically, a patient should reach MMI six months after the type of shoulder surgery Wright received. Dr. Singer opined that the severity of Wright's industrial injury seemed less than the severity

³⁹ Ex. 3 at 30-31.

⁴⁰ Ex. 3 at 35.

⁴¹ Ex. 3 at 33.

⁴² Trial Test.

⁴³ Ex. 3 at 12-13.

⁴⁴ Ex. 3 at 14-18.

of Wright's pain complaints, and he believed Wright exaggerated his pain complaints during his examination.⁴⁵ Dr. Singer testified that when Wright enumerated the activities which caused shoulder pain or which were limited by Wright's shoulder pain, Wright did not express difficulties with activities of daily living such as getting dressed, bathing, and brushing his teeth or hair until Dr. Singer specifically asked him about those activities. Dr. Singer stated that this omission made him doubt the veracity of Wright's complaints.⁴⁶

¶ 36 Jeffrey N. Hansen, M.D., evaluated Wright's left shoulder and cervical spine on September 12, 2006.⁴⁷ Dr. Hansen is board-certified in orthopedic surgery with a certificate of qualification in hand surgery.⁴⁸ Although Dr. Hansen allowed his board certification to lapse at one point, he recertified in 2007.⁴⁹ Dr. Hansen worked as an orthopedic surgeon at Orthopedics Associates in Billings, Montana, from 1986 until the summer of 2000.⁵⁰ Dr. Hansen testified that he left the practice of medicine in 2000 due to personal health issues.⁵¹ Dr. Hansen's Montana medical license was on inactive status in 2000. It returned to active status in 2001, but he was in a probationary program with the Montana Board of Medical Examiners at that time. Approximately two to three years later, his license became unencumbered.⁵² In 2001, Dr. Hansen opened a practice in Billings as an orthopedics surgeon, performing hand surgery and general orthopedic surgery. He ran that practice for approximately four years.⁵³

¶ 37 Dr. Hansen has resided in Powell, Wyoming, since May 2006.⁵⁴ Wright travels to Powell to see him.⁵⁵ Dr. Hansen testified that he is licensed to practice medicine in both

⁴⁵ Singer Dep. 9:21 -11:6.

⁴⁶ Singer Dep. 15:19 - 16:8.

⁴⁷ Ex. 3 at 5.

⁴⁸ Hansen Dep. 9:15-19.

⁴⁹ Hansen Dep. 16:12-19.

⁵⁰ Hansen Dep. 8:13-19.

⁵¹ Hansen Dep. 10:9-14.

⁵² Hansen Dep. 11:8-20.

⁵³ Hansen Dep. 13:12-19.

⁵⁴ Hansen Dep. 6:7-13.

⁵⁵ Wright Dep. (2007) 23:7-12.

Montana and Wyoming;⁵⁶ however, he acknowledged that he does not keep track of his Montana license and that it may be expired.⁵⁷ Dr. Hansen has admitting privileges at the Powell Community Hospital.⁵⁸ Dr. Hansen works as a full-time orthopedic surgeon in Powell's hospital and clinic system. He estimates that his practice is approximately one-half hand and upper extremity surgery and one-half general orthopedics.⁵⁹ Dr. Hansen performs any type of orthopedic surgery except for complex pediatric orthopedics and spine surgery.⁶⁰ Dr. Hansen is also the chief of surgery at Powell Community Hospital.⁶¹

¶ 38 Upon physical examination, Dr. Hansen noted that Wright had a positive Spurling's maneuver and tenderness in the area of his scapular spine incision. Dr. Hansen noted slightly diminished shoulder abduction strength due to pain and possible atrophy of the supra and infraspinatus. Dr. Hansen found no significant crepitus.⁶² Dr. Hansen reviewed Wright's most recent MRI and noted "some question" about the rotator cuff. He saw no evidence of a pathologic condition around the scapula, but saw mild to moderate spondylitic narrowing of the neural foramen at C5-6 and C6-7. Dr. Hansen opined that Wright had significant discomfort originating in his cervical spine which overlaps his shoulder pain. He added:

The only thing I would wonder about with respect to his shoulder is the status of the suprascapular nerve. The operative report suggests that the suprascapular nerve is intact. It does not report whether or not the suprascapular nerve was freed from the scapular notch when the ganglion was excised. If it wasn't, it is possible that the nerve is entrapped and he is having some pain from that. The patient also may have a partial thickness cuff tear. . . . That is also a situation that can gradually progress, even if it

⁵⁶ Hansen Dep. 17:1-3.

⁵⁷ Hansen Dep. 46:3-20.

⁵⁸ Hansen Dep. 17:6-8.

⁵⁹ Hansen Dep. 15:14-21.

⁶⁰ Hansen Dep. 16:20-25.

⁶¹ Hansen Dep. 16:3-11.

⁶² Ex. 3 at 5.

was partial thickness to start with. It could end up getting to be a more severe cuff tear.⁶³

¶ 39 Dr. Hansen further noted:

The patient is fairly well settled into a pain pattern. Because it seems as though he has pain coming from both his neck and his shoulder, it may well be difficult to relieve his painful condition. I personally would recommend a repeat EMG of the upper extremity and make sure that the suprascapular nerve was checked. In fact, if the examiner was comfortable with a previous normal EMG, I would isolate the study just to the suprascapular nerve to make sure there is not denervation of the supraspinatus and infraspinatus. If that is intact, one would really have question as to whether or not further surgery would help him. I do know that a partial thickness cuff tear can cause pain and occasionally it is even best to complete that tear and debride it and clean it up and primarily approximate full thickness healthy tendon tissue. This patient's pain does not seem to all be coming from the subacromial space, however.

In addition, I would suggest that a spine surgeon give us a valid report concerning the cervical spine. . . . I do think that ultimately, he may well come to an anterior cervical discectomy and fusion at two levels. . . .⁶⁴

¶ 40 Dr. Hansen stated that when he initially examined Wright, he believed that some of Wright's symptoms were originating in his neck.⁶⁵ From x-rays, Dr. Hansen found that Wright had some spondylitic narrowing of the spinal canal or foramen.⁶⁶ As for Wright's shoulder, Dr. Hansen suggested examining the suprascapular nerve for signs of entrapment. Dr. Hansen testified that he could not tell from the surgical notes whether the suprascapular nerve had been fully decompressed, and it was possible that it had become entrapped.⁶⁷ Dr. Hansen also believed that a better treatment for Wright's partial rotator cuff tear may have been to complete the tear and repair it, rather than the acromioplasty

⁶³ Ex. 3 at 6.

⁶⁴ Ex. 3 at 6.

⁶⁵ Hansen Dep. 25:13-24.

⁶⁶ Hansen Dep. 26:10-14.

⁶⁷ Hansen Dep. 26:16-24.

which was performed.⁶⁸ Dr. Hansen recommended an MRI of the shoulder and possibly an arthroscopy. He also recommended having a spine surgeon examine Wright's surgical spine.⁶⁹ Dr. Hansen opined that Wright's pain was related to his shoulder and cervical conditions and was not a separate pain syndrome.⁷⁰

¶ 41 On October 24, 2006, Patricia A. LaHaie, M.D., informed Dr. Hansen that she had seen Wright for an electrodiagnostic consultation. Dr. LaHaie found symmetric upper extremity reflexes but had difficulty testing Wright's strength around his left shoulder due to pain. Nerve conduction studies on Wright's left arm were all within normal limits. Dr. LaHaie found no evidence of an ongoing neurogenic process affecting Wright's left arm.⁷¹

¶ 42 Dr. Hansen saw Wright for a follow-up appointment on December 29, 2006. Wright reported that he experienced popping, clicking, and grating in the shoulder when he moved his arm and had a great deal of pain. Dr. Hansen further noted swelling in the supraclavicular area and a possible cervical spine injury. Dr. Hansen found a positive Spurling's maneuver to the left, fullness in the supraclavicular region on the left, and subacromial crepitus and pain in the left shoulder. Dr. Hansen performed a subacromial injection. Within 15 minutes, Wright reported an improvement in his pain by about 70 to 80 percent.⁷² Dr. Hansen testified that this supported his diagnosis that while Wright may have other conditions which are contributing to his pain, Wright also has a problem with his rotator cuff.⁷³

¶ 43 Dr. Hansen noted that he believed Wright has residual subacromial impingement, grating, and crepitus. Dr. Hansen noted that Wright might have developed a cuff tear since his last MRI or had some other change in his condition since the surgery. Dr. Hansen noted that although Wright's cuff appeared intact at the time of surgery, a partial thickness tear was debrided. The partial tear may have become a full thickness tear in the interim. Dr. Hansen recommended an MRI of the brachial plexus area and the supraclavicular area to investigate the mass in the supraclavicular area. Dr. Hansen also

⁶⁸ Hansen Dep. 26:25 - 27:7.

⁶⁹ Hansen Dep. 27:8-17.

⁷⁰ Hansen Dep. 28:1-3.

⁷¹ Ex. 3 at 8.

⁷² Ex. 3 at 3.

⁷³ Hansen Dep. 29:1 - 30:21.

recommended re-imaging Wright's cervical spine, supraclavicular area, and possibly his shoulder. Dr. Hansen opined that Wright could benefit from a repeat arthroscopy.⁷⁴ On December 29, 2006, Dr. Hansen took Wright off work, noting that he had ongoing left shoulder and cervical spine pain.⁷⁵

¶ 44 On May 7, 2007, Dr. Hansen examined Wright, noting a mildly positive Spurling's sign, some tenderness in various regions around his shoulder, and some limitations in strength and range of motion due to pain.⁷⁶ Dr. Hansen recommended a new EMG, a cervical MRI, and a consultation with a spine surgeon, specifically Steven J. Rizzolo, M.D.⁷⁷

¶ 45 On July 11, 2007, Wright saw Dr. Rizzolo. Dr. Rizzolo reviewed Wright's medical history and examined him. Dr. Rizzolo also reviewed available radiology reports and films. Dr. Rizzolo opined that Wright had developed a chronic pain syndrome. Dr. Rizzolo further opined that it was "extremely unlikely" that Wright had significant cervical pathology, although he recommended a C4 nerve block to rule out the possibility of a C4 radiculitis. Dr. Rizzolo declined to opine whether Wright was capable of working at that time.⁷⁸

¶ 46 James S. Elliott, M.D., saw Wright for a second opinion on September 25, 2007. Dr. Elliott opined that Wright suffered from RSD "or at least a painful causality associated with [his] left upper extremity." He recommended a repeat MRI with contrast.⁷⁹ The imaging was performed on October 5, 2007. An arthrogram showed what one radiologist characterized as "abnormal accumulation of contrast in the cuff tendon" which indicated a lineal partial thickness tear.⁸⁰ However, another radiologist opined that the films showed tendinosis, but no definite tear.⁸¹ On October 9, 2007, Dr. Elliott reported that the MRI

⁷⁴ Ex. 3 at 4.

⁷⁵ Ex. 3 at 3.

⁷⁶ Ex. 3 at 324.

⁷⁷ Ex. 3 at 325.

⁷⁸ Ex. 3 at 275-78.

⁷⁹ Ex. 3 at 310-11.

⁸⁰ Ex. 3 at 312.

⁸¹ Ex. 3 at 313.

arthrogram showed no evidence of a rotator cuff tear, but a slight thickening of the subscapularis and anterior formation of the rotator cuff consistent with tendinosis. Dr. Elliott noted some light fraying in the region Dr. Kopplin had debrided. Dr. Elliott opined that Wright would not benefit from additional surgery.⁸²

¶ 47 On April 4, 2008, Michael H. Schabacker, M.D., assumed Wright's care for pain management.⁸³ Dr. Schabacker specializes in chronic pain management.⁸⁴ At the initial consultation, Wright reported that he had constant pain in his left shoulder. Dr. Schabacker summarized Wright's medical records, took a history and conducted a physical examination, and reviewed radiology reports. Dr. Schabacker characterized Wright's left shoulder pain as having an onset correlating with his industrial injury. He opined that the nature of Wright's pain was likely nociceptive and partially neuropathic. Dr. Schabacker opined that Wright could not be expected to use his left arm at work for repetitive activities or lifting. Dr. Schabacker further noted that cervical pathology could be contributing to Wright's pain, and he thought a cervical MRI would be helpful. Dr. Schabacker continued Wright's pre-existing Percocet prescription.⁸⁵

¶ 48 Dr. Schabacker continued to provide Wright with pain management. On July 11, 2008, Vocational Rehabilitation Counselor Travis Stortz sent Dr. Schabacker several job analyses to consider for Wright.⁸⁶ Dr. Schabacker disapproved a job analysis for bread wrap operator; approved job analyses with modification for bread slicer operator and dump truck driver; and approved job analyses for drafter/data collector, receptionist/operator, security officer, courtesy van driver/porter, and network computing technician.⁸⁷

¶ 49 Dr. Schabacker testified that in reviewing the submitted job analyses, he took into account the physical demands of each job, the objective medical findings of Wright's condition, and Wright's pain complaints.⁸⁸ Dr. Schabacker found Wright at MMI on October 8, 2008, and he believes Wright remained at MMI at the time of Dr. Schabacker's

⁸² Ex. 3 at 314.

⁸³ Ex. 3 at 279.

⁸⁴ Schabacker Dep. 4:11-13.

⁸⁵ Ex. 3 at 279-84.

⁸⁶ Ex. 3 at 291-92.

⁸⁷ Ex. 3 at 293-300.

⁸⁸ Schabacker Dep. 14:22 - 15:23.

deposition on March 13, 2009.⁸⁹ Dr. Schabacker opined that while Wright believes he cannot work, Dr. Schabacker believes that “there is something that he can do from a work standpoint” in spite of his subjective complaints of pain.⁹⁰ Dr. Schabacker added that he believes Wright’s complaints of pain are real and he does not believe Wright is malingering or lying about his pain.⁹¹

¶ 50 On October 8, 2008, Dr. Schabacker noted:

His pain in his left shoulder and arm has a neuropathic component. Mr. Wright may have some permutation of a complex regional pain syndrome-type condition, although he does not have classic CRPS. Unfortunately, I do not believe there is any specific treatment that will be curative or holds much promise for a dramatic reduction in the amount of discomfort.⁹²

¶ 51 On January 12, 2009, Dr. Schabacker noted that Wright was unhappy with the 6% whole person impairment rating he had been given after reaching MMI. Dr. Schabacker noted that he attempted to explain to Wright that the calculation was based on a textbook and was not a subjective determination. Dr. Schabacker further noted that Wright was unhappy about the job analyses which Dr. Schabacker had approved, and asserted that he could not perform those jobs. Dr. Schabacker noted:

On review of those JAs, it is clear that repetitive use of the left upper extremity would be necessary. Mr. Wright has been consistent in his report of left shoulder pain. His behavior relative to his left shoulder has been unchanged through time. He is consistent in his report that any repetitive movement of his left shoulder is not well-tolerated. On reanalysis, I question whether Mr. Wright is capable of driving or operating a truck, which he states he is not capable of. Additionally, he does not believe that he is capable of operating a bread slicer or working as a receptionist, etc. Overall, it seems clear that Mr. Wright’s focus and his pain is consistent. There is some doubt

⁸⁹ Schabacker Dep. 17:11-17.

⁹⁰ Schabacker Dep. 21:1-13.

⁹¹ Schabacker Dep. 29:11-21.

⁹² Ex. 3 at 301.

as to whether he is capable of return to work and perhaps is not capable of return to work.⁹³

¶ 52 On April 20, 2009, Dr. Hansen examined Wright and noted that the majority of Wright's pain was in the left side of his neck. Dr. Hansen saw symptoms of radicular irritation. Dr. Hansen injected Wright's neck. Wright reported pain relief of about 70% within 10 minutes. Dr. Hansen reviewed a cervical MRI and noted that Wright had some irregular findings at C5-6 and C6-7. Dr. Hansen opined that a repeat arthroscopy might help Wright's pain, but they needed to formulate a more specific diagnosis and plan.⁹⁴

¶ 53 Wright returned to see Dr. Hansen on June 1, 2009. Dr. Hansen reviewed the pain relief Wright had gotten from the previous injection and opined that Wright had mechanical neck pain relating to an underlying cervical spine pathology. Dr. Hansen believed Wright could be a candidate for anterior cervical decompression and fusion. Dr. Hansen further noted that Wright had ongoing impingement, bicipital tendinitis and probably some labral pathology in his left shoulder. Dr. Hansen opined that Wright would have a significant chance of improvement with another procedure on his left shoulder. He suggested that if a partial cuff tear was present, Wright might benefit from completing the tear and reattaching it. Dr. Hansen opined that Wright was symptomatic but stable, but also unemployable due to his cervical spine and shoulder problems.⁹⁵

¶ 54 On September 30, 2009, Wright returned to see Dr. Hansen and reported that his symptoms were increasing. Dr. Hansen noted that Wright had more pain along the medial border of the scapula, a stiffer neck, more pain around his shoulder, and headaches. Dr. Hansen found that Wright had diminished range of motion in his cervical spine, tenderness at the occipital insertion of the paraspinal muscle, tenderness along the spine of the scapula and along the medial border, some atrophy in the infraspinatus and supraspinatus fossa, tenderness and a bony prominence over the AC joint, and some crepitus with rotation of the shoulder. Dr. Hansen obtained new neck and shoulder x-rays and found significant degenerative disk disease at C5-6 and C6-7. The shoulder films showed a type 2 or type 3 acromion, some recurrent calcification in the area of the AC joint resection, and "clearcut evidence of chronic impingement with sclerosis in the fossa just medial to the greater tuberosity."⁹⁶ Dr. Hansen opined:

⁹³ Ex. 3 at 305.

⁹⁴ Ex. 3 at 320.

⁹⁵ Ex. 3 at 321.

⁹⁶ Ex. 3 at 322.

With respect to symptoms, I continued to believe this man has both cervical disc disease causing significant amount of his neck pain and headaches and may be even some of the shoulder pain. He also probably has recurrent or persistent impingement based on his plain x-rays in his exam alone. He has some myofascial trigger points along the medial border of the scapula, which remain symptomatic.

. . .

I believe he will eventually come to an anterior cervical decompression and fusion. It is unpredictable, but most of the time when that procedure is done, the neck pain and headache is significantly diminished. . . .

With respect to his shoulder, it is really hard to know for sure if he can be helped there. I suspect that if he is arthroscoped and a revision acromioplasty done, one would find enough pathology in his rotator cuff that he would probably end up with a full-blown rotator cuff repair. I think he is going on to a full-blown impingement. He also is very tender in the biceps. He previously had a partial labral debridement and when the biceps is left attached and part of the labrum has been debrided, it often times leaves to persistent labral pain and eventually needs further labral debridement and biceps tenodesis.

. . . .

I would schedule him for arthroscopic surgical intervention with procedures as indicated up and including biceps tenodesis, rotator cuff repair, and review of subacromial decompression. I would also remove that calcification from the AC joint and see if that helped him as well.⁹⁷

Dr. Hansen further noted that Wright's chronic pain possibly would not be relieved by these procedures. He opined that Wright's shoulder and cervical conditions were caused by or made symptomatic by his industrial injury. He explained that while the cervical condition is degenerative, the accident which injured his shoulder and the shoulder injury itself were both significantly likely to have exacerbated the underlying condition.⁹⁸

⁹⁷ Ex. 3 at 322-23.

⁹⁸ Ex. 3 at 323.

¶ 55 Dr. Hansen testified that two potentially pain-relieving surgical repairs which Wright might benefit from would be a biceps tenodesis, and completion of Wright's partial rotator cuff tear with rotator cuff repair. Dr. Hansen stated that both of these procedures could be performed arthroscopically.⁹⁹

¶ 56 Dr. Hansen opined that Wright has degenerative disk disease of the cervical spine, primarily at C5-6 and C6-7, with nerve root irritation and secondary neck pain and headache. He further opined that Wright has an element of persistent or recurrent subacromial impingement, with partial thickness rotator cuff tear and labral degeneration with biceps tendonitis.¹⁰⁰ The objective medical findings which support Dr. Hansen's diagnosis are an MRI showing disk degeneration at C5-6 and C6-7, and findings on physical exam including a positive Spurling's maneuver, symptomology on examination of the shoulder, and the first MRI and arthroscopy findings which confirmed pathology in the labrum.¹⁰¹ Dr. Hansen further opined that, within a reasonable degree of medical probability, Wright's industrial injury caused or aggravated an underlying condition regarding both Wright's shoulder and cervical conditions.¹⁰² Dr. Hansen further opined that Wright's pain from these injuries have rendered him unable to work since some time in 2006.¹⁰³ Dr. Hansen has not considered any job analyses for Wright.¹⁰⁴

¶ 57 Dr. Hansen explained:

I believe [Wright's] pain has become such a distraction to him mentally that . . . it would be hard to concentrate. I don't see how he would be at all competitive in the work force. . . . [T]here would be days when he couldn't show up for work and there are days when he'd need pain medication and it would be too distracting.

. . .

⁹⁹ Hansen Dep. 37:24 - 38:8.

¹⁰⁰ Hansen Dep. 42:22 - 43:4.

¹⁰¹ Hansen Dep. 43:5-19.

¹⁰² Hansen Dep. 44:15-22.

¹⁰³ Hansen Dep. 44:23 - 45:5.

¹⁰⁴ Hansen Dep. 57:1-10.

[C]onceptually . . . there are things that a person could do. But as far as truly being gainfully employed in a competitive work force, where someone more capable could do that job, I just don't see who's going to hire him.¹⁰⁵

¶ 58 Wright testified that he believes it would be dishonest of him to represent to a prospective employer that he believes he could fulfill his job duties as an employee. He further noted that he would be obligated to tell prospective employers about his use of prescription medication.¹⁰⁶ Wright stated that he experiences side effects from his medications, including drowsiness and an inability to concentrate. He does not believe he can safely drive or operate machinery while he is taking his prescription medication because he has difficulty focusing on the task.¹⁰⁷

¶ 59 The only employment Wright has had since leaving Interstate Brands was a few shifts as a security officer for Metra Park events during the summer of 2007. Wright testified that his job duties were to walk around the event and to watch and report any problem behavior. The job duties substantially increased his pain because of the weight of his arm pulling on his shoulder as he walked. Although he at most worked only one day a week, he found the job to be too demanding with his shoulder pain and he quit.¹⁰⁸

¶ 60 Wright stated that he has difficulty driving for any distance because steering with his right arm affects his left shoulder as well. He drove for 90 minutes to see Dr. Hansen in Powell, Wyoming, but his wife had to drive on the trip home because he was in too much pain.¹⁰⁹ Wright also testified that while he understands the surgical procedure recommended by Dr. Hansen may not be successful, he would like to have the surgery because he believes his only other alternative is to remain in severe pain.¹¹⁰

¶ 61 Wright testified that although he attempted to stay active by walking around his neighborhood, at the present time he no longer walks any distance because of the severity of his pain. He further testified that he is able to carry light objects with his left hand, but

¹⁰⁵ Hansen Dep. 62:12-25.

¹⁰⁶ Trial Test.

¹⁰⁷ Trial Test.

¹⁰⁸ Trial Test.

¹⁰⁹ Trial Test.

¹¹⁰ Trial Test.

anything greater than a few pounds in weight significantly increases his shoulder pain. He also experiences increases in pain if he attempts to lift his left arm higher than chest height.¹¹¹

¶ 62 Bette M. Wright (Bette), Wright's wife, testified at trial. I found Bette to be a credible witness. Bette testified that prior to Wright's industrial accident, they were an active couple and enjoyed activities such as bowling and camping. Since his injury, Wright's pain has limited his abilities and they no longer participate in many activities. Bette further testified that Wright has become depressed since the injury and that he is unhappy that more responsibilities have fallen on Bette since Wright is no longer able to work or perform many of the household chores Wright used to complete.¹¹²

¶ 63 Travis Stortz, Vocational Rehabilitation Counselor, was sworn and testified at trial. I found Stortz to be a credible witness. Stortz is a Certified Rehabilitation Counselor. ACE hired Stortz to provide vocational rehabilitation services to Wright. Stortz determined that Wright would require some remedial education, and he assisted Wright in enrolling in adult education classes. Stortz maintained occasional contact with Wright after Wright began attending class. Stortz testified that Wright missed some classes and then decided to stop attending. He informed Stortz that he was treating with a doctor in Wyoming. After that, Stortz had little contact with Wright.¹¹³

¶ 64 Wright testified that he attempted to complete a vocational rehabilitation program in 2006, but he frequently missed classes because of pain and he was unable to complete the training.¹¹⁴

¶ 65 Stortz prepared some job analyses which were submitted to Dr. Schabacker for approval. Stortz testified that the job analyses represent actual jobs which exist in the local labor market and that they are representative of other, similar jobs which also exist in the local labor market. He further stated that the entry-level jobs he analyzed were jobs with regular turnover. Stortz stated that, based on the vocational information he obtained about Wright, he believes that Wright is vocationally qualified to perform the jobs analyzed. Stortz testified that he has no medical expertise or training and that his opinion

¹¹¹ Trial Test.

¹¹² Trial Test.

¹¹³ Trial Test.

¹¹⁴ Trial Test.

is strictly limited to vocational ability; he relies on medical providers to opine whether a person can physically do the jobs.¹¹⁵

CONCLUSIONS OF LAW

¶ 66 This case is governed by the 2003 version of the Montana Workers' Compensation Act (WCA) since that was the law in effect at the time of Wright's industrial accident.¹¹⁶

¶ 67 Wright bears the burden of proving by a preponderance of the evidence that he is entitled to the benefits he seeks.¹¹⁷

Issue One: Whether the insurer is liable for payment of additional medical benefits and temporary total disability benefits to the Petitioner.

¶ 68 Wright asks this Court to order ACE to pay for the surgical procedure Dr. Hansen proposes. Wright argues that over the course of five years, he has been seen by 15 doctors, all of whom – except Dr. Singer – agree that his pain is real, but that only Drs. Schabacker and Hansen have offered him any treatment options to alleviate the pain.¹¹⁸ ACE responds that Wright has been seen by approximately 15 Montana doctors who have found that nothing more can be done to improve Wright's condition. ACE argues that the opinion of one former Montana surgeon who now practices in Wyoming should not be given greater weight.¹¹⁹

¶ 69 Section 39-71-116(36), MCA, sets forth the criteria which must be met for a person to be considered a "treating physician" under the WCA. Section 39-71-116(36)(a), MCA, states that this person must be "a physician licensed by the state of Montana . . . and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located. . . ." Under this definition, Dr. Hansen cannot qualify as a treating

¹¹⁵ Trial Test.

¹¹⁶ *Buckman v. Montana Deaconess Hosp.*, 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¹¹⁷ *Ricks v. Teslow Consol.*, 162 Mont. 469, 512 P.2d 1304 (1973); *Dumont v. Wickens Bros. Constr. Co.*, 183 Mont. 190, 598 P.2d 1099 (1979).

¹¹⁸ Petitioner's Trial Brief at 1, Docket Item No. 35.

¹¹⁹ [Respondent's] Trial Brief at 3, Docket Item No. 33.

physician. Although Dr. Hansen has admitting privileges to practice in a hospital in the area in which he is located, his Montana license has apparently expired.

¶ 70 The medical provider who qualifies as Wright's treating physician under the WCA is Dr. Schabacker, who provides Wright with pain management. It is clear from the evidence before the Court and from witnessing Wright's live testimony that Wright suffers from severe pain.

¶ 71 Although the parties frame Wright's entitlement to benefits as a single issue, the Court actually must make three distinct determinations:

¶ 71a Whether ACE is liable for the shoulder surgery Dr. Hansen proposes.

¶ 71b Whether ACE is liable for diagnosis and treatment of the cervical condition Dr. Hansen believes Wright may be suffering from.

¶ 71c Whether Wright is entitled to additional TTD benefits.

Whether ACE is liable for the shoulder surgery Dr. Hansen proposes.

¶ 72 Regarding the proposed shoulder surgery, as a general rule, the opinion of a treating physician is accorded greater weight than the opinions of other expert witnesses. However, a treating physician's opinion is not conclusive. To presume otherwise would quash the role of the fact finder in questions of an alleged injury. As the finder of fact, this Court remains in the best position to assess witnesses' credibility and testimony.¹²⁰

¶ 73 In cases where the opinions of medical experts conflict, the opinion of the treating physician is often found most persuasive by the Court. In many instances, this is due at least in part to the treating physician's greater expertise or greater familiarity with the claimant.¹²¹ At a minimum, the treating physician is the tiebreaker where the Court finds evenly balanced, conflicting medical testimony.¹²² Often, the Court finds the treating physician more persuasive because, in the Court's opinion, that physician is more qualified

¹²⁰ *EBI/Orion Group v. Blythe*, 1998 MT 90, 288 Mont. 356, ¶¶ 12-13, 957 P.2d 1134 (1998).

¹²¹ See, e.g., the Court's recent decision in *Johnson v. Liberty Northwest Ins. Corp.*, 2009 MTWCC 20, ¶ 86, in which the Court was persuaded by the opinions of a doctor who was the claimant's treating physician and whom the Court found to have a superior background and experience and an extensive practice of treating similarly-afflicted patients.

¹²² *Wall v. Nat'l Union Fire Ins. Co.*, 1998 MTWCC 11, ¶ 67.

under the specific facts of the case. For example, in *Healy v. Liberty Northwest Ins. Corp.*, the Court found the opinion of the claimant's most recent treating physician more persuasive than his former treating physician because he had seen the latter not only more recently but also on more occasions than he had the former.¹²³ The Court has also found the opinion of nontreating physicians more persuasive than the treating physician based in part on the greater expertise of the nontreating physicians.¹²⁴

¶ 74 In the present case, Dr. Schabacker, a specialist in chronic pain management, is Wright's treating physician. I have no doubt that Dr. Schabacker is well-qualified in the field of chronic pain management, and I find Dr. Schabacker's opinions credible. Dr. Schabacker's opinions, however, go to the **reality** of Wright's pain and how to best manage it. Dr. Schabacker's opinions do not go to the cause of Wright's pain and whether additional medical treatment could eliminate it.

¶ 75 On the other hand, Dr. Hansen's expertise and qualifications cause me to give his opinion as to the likely causes and potential treatment of Wright's shoulder condition greater weight. The issue before the Court is not an issue of pain management – it is an orthopedic issue and whether orthopedic surgery is indicated. I find the opinion of this orthopedic surgeon to be more persuasive, even though he is not considered Wright's treating physician under Montana law. Dr. Hansen is more specialized regarding the diagnosis and treatment of Wright's shoulder condition, he has personally examined Wright on multiple occasions, and he regularly treats other patients with shoulder conditions in his practice. I therefore conclude that ACE is liable for additional medical benefits in the form of the surgical procedure Dr. Hansen proposes for Wright's shoulder.

Whether ACE is liable for diagnosis and treatment of the cervical condition Dr. Hansen believes Wright may be suffering from.

¶ 76 As to the issue of the cervical condition, as the findings indicate above, Dr. Hansen believes Wright is likely suffering from a cervical condition which is causing a significant portion of his pain. However, Dr. Hansen is not a spinal surgeon and as of the time of trial, Wright did not have a spinal surgeon who agreed with Dr. Hansen's diagnosis. Since 2005, ACE has sent Wright to see a myriad of doctors in pursuit of a diagnosis of, and possible treatments for, Wright's ongoing pain complaints. While I believe Dr. Hansen's

¹²³ 2007 MTWCC 43, ¶ 49.

¹²⁴ See, e.g., *Frisbie v. Champion Int'l Corp.*, 1995 MTWCC 13 at 11, in which the Court gave greater weight to the opinions of two nontreating physicians who specialized in the treatment of low-back conditions over the opinion of the claimant's treating physician, who was a family practitioner.

opinion as to Wright's cervical condition warrants further investigation, I am unwilling to issue an open-ended order that would make ACE liable for Wright to essentially "doctor shop" until he finds a spinal surgeon willing to perform the procedure Dr. Hansen recommends.

¶ 77 I believe the Court's decision in *Beyl v. Liberty Northwest Ins. Corp.*¹²⁵ offers a reasonable solution. In *Beyl*, the claimant injured his right elbow in an industrial accident.¹²⁶ Dr. Dean C. Sukin, an orthopedic surgeon, performed an IME on the claimant and recommended a surgical procedure.¹²⁷ The claimant's treating physician – Dr. James F. Schwarten, also an orthopedic surgeon – opined that the surgery was not warranted.¹²⁸ After considering the evidence, this Court found Dr. Sukin's opinion more persuasive, but noted that Dr. Sukin would not perform this surgery personally since he had conducted the IME. Recognizing that the claimant was entitled to medical benefits for the surgery, but also recognizing that the claimant was without a surgeon who agreed with this determination who was also willing to perform the surgery, this Court concluded as follows:

Claimant is entitled to medical benefits for surgery should claimant find a physician willing to perform the surgery. However, in light of the unique nature of the evidence in this case, reasonable time limitations must be placed on any surgery. . . . Claimant must . . . convince Dr. Schwarten, as he has the Court, that surgery is reasonable and necessary. If he cannot do so, then he must find another treating physician who will agree to the surgery. Theoretically, he might run through several orthopedic surgeons before he finds one willing to do the surgery, or he might take years to find one, or he might expend years searching and never find one. Consequently, limits must be placed on his search for a willing surgeon.

. . .

Claimant must return to Dr. Schwarten and ask him to review his case in light of Dr. Sukin's opinion and this Court's decision. If Dr. Schwarten agrees that surgery is appropriate, then Liberty shall pay for such surgery and pay claimant TTD benefits until he reaches MMI from the surgery. If Dr.

¹²⁵ 2000 MTWCC 75.

¹²⁶ *Beyl*, ¶ 7.

¹²⁷ *Beyl*, ¶¶ 29-30.

¹²⁸ *Beyl*, ¶ 31.

Schwarten does not agree that surgery is appropriate, then claimant shall designate another orthopedic physician practicing in Montana to evaluate him and determine whether surgery is appropriate. Liberty shall pay for the consultation. If that surgeon agrees that surgery is appropriate, then Liberty shall pay for the surgery. Thus, claimant has two opportunities to secure surgery. If the second physician recommends against surgery, then that is the end of it and at that point claimant shall be deemed at MMI and Liberty's liability for TTD benefits shall end.

The Court then set deadlines for the claimant to obtain his reevaluation from Dr. Schwarten and his subsequent evaluation by another orthopedic surgeon, if necessary.¹²⁹

¶ 78 In the present case, Dr. Hansen sent Wright to Dr. Rizzolo for his opinion on whether Wright had a cervical condition which could benefit from surgery. At the time, Dr. Rizzolo disagreed with Dr. Hansen's diagnosis although he suggested a nerve block to rule out one possible diagnosis. As the Court ruled in *Beyl*, I am ordering in this case that Wright return to Dr. Rizzolo and ask him to review his determination in light of Dr. Hansen's findings and this Court's decision. If Dr. Rizzolo agrees that further treatment of Wright's cervical spine is warranted, ACE shall pay for the treatment including surgery and TTD benefits if warranted. If Dr. Rizzolo is unconvinced, Wright may designate another orthopedic physician practicing in Montana to evaluate him and determine whether surgery or other treatment is appropriate. ACE shall pay for the consultation. If that surgeon agrees that surgery or other treatment to Wright's cervical spine is appropriate, ACE shall pay for that treatment. If the second orthopedic surgeon also recommends against further treatment, then ACE will not be liable for further treatment of Wright's alleged cervical condition.

Whether Wright is entitled to additional TTD benefits.

¶ 79 As to Wright's entitlement to TTD benefits, under § 39-71-701, MCA, a worker is eligible for TTD benefits when he suffers a total loss of wages as a result of an injury and until he reaches maximum healing, or until he has been released to return to the employment in which he was engaged at the time of the injury or to employment with similar physical requirements. Although Dr. Schabacker and other medical providers approved some job analyses for Wright, Wright has not been released to return to his time-of-injury employment or employment with similar physical requirements. Section 39-71-116(18), MCA, defines maximum healing or MMI as the point in the healing process when further material improvement would not be reasonably expected from primary medical

¹²⁹ *Beyl*, ¶¶ 51-53.

treatment. In the present case, I have determined that Wright is entitled to additional medical treatment on his shoulder and potentially on his cervical spine which I have concluded would reasonably be expected to materially improve his condition. Therefore, Wright is not at MMI. Since he is not at MMI, he is entitled to TTD benefits pursuant to § 39-71-701, MCA.

Issue Two: Whether Petitioner is entitled to an award of reasonable attorney fees and costs from the Respondent.

¶ 80 As the prevailing party, Wright is entitled to his costs.¹³⁰ As to the issue of attorney fees, I may award reasonable attorney fees to the claimant if I determine that the insurer's actions were unreasonable. In the present case, Wright has not alleged that ACE has been unreasonable. Rather, he argues that he should receive his attorney fees and a penalty because he cannot afford to pay his attorney out of any award he may receive in this case. This does not provide a statutory basis for an award of attorney fees. Therefore, Wright is not entitled to an award of attorney fees.

Issue Three: Whether Petitioner is entitled to the 20% penalty from the Respondent.

¶ 81 Under § 39-71-2907, MCA, I may increase by 20% the full amount of benefits due a claimant during a period of delay or refusal to pay if the insurer's delay or refusal to pay is unreasonable. For the same reasons discussed above at ¶ 80, Wright is not entitled to a 20% penalty.

Issue Four: For such additional relief as the Court may deem appropriate.

¶ 82 Under § 39-71-2905, MCA, a claimant or an insurer who has a dispute concerning any benefits under Title 39, chapter 71, may petition the workers' compensation judge for a determination of the dispute after satisfying the WCA's dispute resolution requirements. Under § 39-71-2401(1), MCA, a dispute concerning benefits arising under the WCA must be brought before a department mediator, and may be brought before this Court only if a dispute still exists after completion of the mediation process. In the present case, Wright asks the Court for unspecified "additional relief." Under *Ricks*,¹³¹ Wright has the burden of proving by a preponderance of the evidence that he is entitled to the benefits he seeks. As to the present issue, Wright has not presented to the Court any specific information as to what additional benefits to which he believes he is entitled. The Court cannot fashion

¹³⁰ *Marcott v. Louisiana Pac. Corp.*, 1994 MTWCC 109 (*aff'd after remand at 1996 MTWCC 33*).

¹³¹ ¶ 67, above.

a remedy without regard to the specific relief available within the WCA and the jurisdictional prerequisite of mediation. Wright's request for "additional relief" is denied.

JUDGMENT

¶ 83 The insurer is liable for payment of additional medical benefits and temporary total disability benefits to the Petitioner as set forth in these Findings of Fact, Conclusions of Law, and Judgment.

¶ 84 Petitioner is entitled to his costs.

¶ 85 Petitioner is not entitled to his attorney fees.

¶ 86 Petitioner is not entitled to a 20% penalty from the Respondent.

¶ 87 Petitioner is not entitled to additional relief.

¶ 88 Pursuant to ARM 24.5.348(2), this Judgment is certified as final and, for purposes of appeal, shall be considered as a notice of entry of judgment.

DATED in Helena, Montana, this 24th day of May, 2010.

(SEAL)

JAMES JEREMIAH SHEA
JUDGE

c: Patrick R. Sheehy
Charles G. Adams
Submitted: January 20, 2010